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REPORT OF CHANGE – Healthy Indiana Plan

State Form 53428 (11-07) / HIP 2519

HEALTHY INDIANA PLAN™
Health Coverage = Peace of Mind

Mail or Fax Completed Form to:
FSSA Document Center
P.O. Box 1630
Marion, IN 46952
Fax #: 1-800-403-0864

Name of case	Case number
Address (number and name, city, state, ZIP code)	Telephone number where you can be reached: ( )

IMPORTANT INFORMATION

Your Social Security number is being requested by this State agency in accordance with 45 CFR 205.52, 7 CFR 273.6, and 42 CFR 435.910. The information obtained on this form is confidential under state and federal regulations, including 470 IAC 1-2-7, 470 IAC 1-3-1, 470 IAC 6-1-1, 405 IAC 1-1-12, 45 CFR 205.50, 7 CFR 272.1(c), and 42 CFR 431.300. This information will not be released except as permitted or required by law or with the consent of the applicant/recipient.

ALL CHANGES MUST BE REPORTED WITHIN 10 DAYS.

1. CHANGE OF ADDRESS

New address (number and street, city, state, ZIP code)	Telephone number ( )	Date moved

2. CHANGE OF PEOPLE IN YOUR HOUSEHOLD

Name of Person	In	Out	Date of Birth	Social Security Number	Date of Change
	☐	☐			
	☐	☐			
	☐	☐			

3. CHANGE IN SOURCE OR AMOUNT OF EARNED INCOME
This includes new employment, raises, promotions and access to employer sponsored health insurance.

Name or person	Type of change	Does this employer offer Health Insurance? ☐ Yes ☐ No	Date of change

Place of employment	Start date	Hourly wage	Expected weekly hours of work

4. DO YOU WANT US TO RECALCULATE YOUR CONTRIBUTION AMOUNT TO THE HIP COVERAGE? ☐ Yes ☐ No
Note: you are allowed one Recalculation related to income changes from the same job or income from a new job in a 12-month period.

5. CHANGE IN SOURCE OR AMOUNT OF UNEARNED INCOME
This includes child support, Social Security, SSI, unemployment, VA benefits, utility checks, contributions, financial aid, etc.

Name of person	Type of change	Date of Change

New amount $	Frequency of amount: ☐ Monthly ☐ Weekly ☐ Other If Other, Specify:

6. HEALTH INSURANCE: Does anyone in the household have health insurance coverage including Medicare? (Do Not List Medicaid)

Name of Person Covered	Insurance Company	Claim Number, Policy or Group Number	Coverage Start Date

7. PREGNANCY: Is anyone in the household pregnant?

Name of Person	Date of Birth	Social Security Number	Date of Expected Delivery	Number of Babies Expected

8. OTHER CHANGES

9. Do you expect the changes you have reported to continue beyond this month? ☐ Yes ☐ No

If no, please explain:

Signature	**Date** (month, day, year)
Telephone number where you can be reached: ( )	Social Security Number

PLEASE ATTACH PROOF OF YOUR CHANGES, IF POSSIBLE.
If you have not heard from FSSA within 10 days of turning in your report, please call 1-800-403-0864
(See the back of this form for more information)

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Information About Reporting Changes For Healthy Indiana Plan

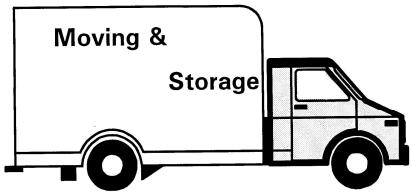
YOU MUST REPORT ALL CHANGES WITHIN 10 DAYS FROM THE TIME YOU KNOW ABOUT THE CHANGE

*(Below are examples of changes you **MUST** report)*

REPORT TO US

When someone MOVES IN or MOVES OUT of your home. When someone in your home gets married, is pregnant, has a baby, or dies. When someone is covered by health insurance. When a divorce is final by court order. When the amount of court-ordered child support you pay changes.

REPORT TO US



When you MOVE.

REPORT TO US

Change in a JOB, a new job, a job ends, an increase or decrease in pay, an employer offers health insurance, or a change in MONEY received such as Child Support or Social Security.

FAILURE TO REPORT CHANGES MAY RESULT IN YOU HAVING TO REPAY BENEFITS

IF YOU HAVE QUESTIONS PLEASE CALL TOLL FREE 1-800-403-0864